

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15959

CERTIFICATE OF DEATH

15950

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. LENGTH OF STAY IN 1b CALLWAY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last AGNES LIGUORI BEAVAN		4. DATE OF DEATH Month Day Year NOV. 4 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 5, 1894
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES PAUL ABELL		14. MOTHER'S MAIDEN NAME CATHERINE ELLEN HAMMETT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. N/A	
17. INFORMANT AGNES DORIS JONES		Address CALLAWAY, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sat Embolism of aorta from atherosclerosis DUE TO Fract. of hip and of humerus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 41	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 3 , 19 67 , to Nov 4 , 19 67 , that (I) (we) lost saw the deceased alive on Nov 3 , 19 67 , and that death occurred at 4:30 PM, from causes and on the date stated above.			
22a. SIGNATURE Michael Barbarich		22b. DATE SIGNED NOV. 5, 1967	
22c. PHYSICIAN'S NAME (Type) MICHAEL BARBARICH, M.D.		22d. ADDRESS LEONARDTOWN, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF NOV. 7, 1967	
23c. NAME OF CEMETERY OR CREMATORY HOLY FACE CEMETERY		23d. LOCATION (City or Town) (County) (State) GREAT MILLS ST. MARY'S MD.	
24. FUNERAL DIRECTOR JOHN M. WELCH		25a. REC'D BY REGISTRAR NOV 7 1967	
ADDRESS LEONARDTOWN, MD.		25b. REGISTRAR'S SIGNATURE James J. Judge	

1883

STATE OF MICHIGAN

1883

IN SENATE

January 1, 1883

REPORT OF THE COMMISSIONER OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE
MAY 1, 1882

ALBION, MICHIGAN: PUBLISHED BY THE STATE OF MICHIGAN, 1883.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15950

CERTIFICATE OF DEATH

15951

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COMPTON		c. LENGTH OF STAY IN 1b 24 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL COMPTON		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First SUSAN Middle ALBERTA Last BOWLES				4. DATE OF DEATH Month NOVEMBER Day 12, Year 19 67			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 10, 1910		9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS D. ELLIS				14. MOTHER'S MAIDEN NAME MARY E. BAILEY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address JOHN I. BOWLES JR. Rt. 1 LEONARDTOWN, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Insufficiency DUE TO (b) metastases to liver DUE TO (c) Adeno Carcinoma Colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH 1 mo. 18 mo. 18 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.							
22a. SIGNATURE John F. Fenwick				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11.15.67	
22c. PHYSICIAN'S NAME (Type) JOHN F. FENWICK M. D.				22d. ADDRESS LEONARDTOWN, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Nov. 15, 1967		23c. NAME OF CEMETERY OR CREMATORY ST. JOSEPH'S CHURCH		23d. LOCATION (City or Town) (County) (State) MORGANZA, ST. MARY'S, MD.	
24. FUNERAL DIRECTOR ADDRESS W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND				25a. REC'D BY REGISTRAR NOV 17 1967		25b. REGISTRAR'S SIGNATURE James J. Judge	

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W. CLARK MATTHEW LEONARDTOWN, MARYLAND

BURIAL

NOV. 12, 1907

ST. JOSEPH'S CHURCH

LEONARDTOWN, MARYLAND

JOHN P. FENNER M. D.

MORGANZA, ST. MARY'S, MD.

ST. MARY'S

MARYLAND

ST. MARY'S

COMPTON

24 YEARS

RURAL

COMPTON

SUBAN

ALBERTA

BOWEN

NOVEMBER 12, 1907

FEMALE WHITE

JUNE 10, 1910

HUSBAND WIFE

MARYLAND

U.S.A.

THOMAS D. ELLIS

MARY E. BAKER

JOHN I. BOWEN JR., ST. LEONARDTOWN, MARYLAND

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MD
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15961

CERTIFICATE OF DEATH

15953

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN				c. LENGTH OF STAY IN 1b 5 DAYS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL				d. STREET ADDRESS RURAL VALLEY LEE.			
3. NAME OF DECEASED (Type or print) First Middle Last FLORA CHRISTINE BRISCOE				4. DATE OF DEATH Month Day Year NOVEMBER 6, 19 67			
5. SEX FEMALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 16, 1921	9. AGE (In years last birthday) 45 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ? ?				14. MOTHER'S MAIDEN NAME AMANDA SOMERVILLE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 214 302426		17. INFORMANT Address ERNEST G. BRISCOE SAME AS # 2 ABOVE			
18. CAUSE OF DEATH (Enter only one cause per life for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acidosis & Circulatory Collapse DUE TO (b) Uremia DUE TO (c) Chronic Glomerulonephritis						INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/6/67 to 11/6/67 , that (I) (we) last saw the deceased alive on 11/6/67 , and that death occurred at 4 AM , from causes and on the date stated above.							
22a. SIGNATURE JAMES B. JARBOE M.D.				22b. DATE SIGNED 11/11/67			
22c. PHYSICIAN'S NAME (Type) JAMES B. JARBOE M.D.				22d. ADDRESS GREAT MILLS, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Nov. 9, 1967		23c. NAME OF CEMETERY OR CREMATORY ST. MARKS CEMETERY		23d. LOCATION (City or Town) (County) (State) VALLEY LEE, ST. MARY'S, MARYLAND	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOW, MARYLAND				25a. REC'D BY REGISTRAR NOV 14 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

1933

CERTIFICATE OF DEATH

1933

ST. MARY'S

MARYLAND

ST. MARY'S

LEHARTOWN

3 DAYS

RURAL VALLEY REC.

ST. MARY'S HOSPITAL

FLORA	CHRISTINE	BRIDGE	NOVEMBER	2
EDMUND	COLBERT	DEC. 16, 1931	45	
HOUSE WIFE		MARYLAND	U.S.A.	

AMANDA BOMERVILLE

EMERSON, R. BRIDGE RAMP NO. 2 ABOVE

[Faint, illegible handwritten text and signatures covering the middle section of the document.]

DEATH WITNESSES, MARYLAND

CHARLES T. JARVIS, M.D.

BURIAL MAY 9, 1932 ST. MARY'S CEMETERY VALLEY REC. ST. MARY'S, MARYLAND

CLARENCE BATTIMOREY LEONARDTOWN, MARYLAND

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15962

15954

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN				c. LENGTH OF STAY IN 1b 4 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ST. GEORGE ISLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARVIN Middle FRANKLIN Last BROWN				4. DATE OF DEATH Month NOVEMBER Day 14 Year 1967			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH AUGUST 1, 1892		9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATERMAN		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME MINNIE CRESSER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT GERALDINE BROWN Address ST. GEORGE ISLAND, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 357X Paralysis of vital centers DUE TO (b) Friedrich's ataxia DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 16 hours 30 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 13, 1967 , to Nov 14, 1967 , that (I) (we) last saw the deceased alive on Nov 13, 1967 , and that death occurred at 12:45 AM , from causes and on the date stated above.							
22a. SIGNATURE P. J. BEAN M.D.				22b. DATE SIGNED Nov 10/67		22c. PHYSICIAN'S NAME (Type)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF Nov. 17, 1967		23c. NAME OF CEMETERY OR CREMATORY ST. GEORGE ISLAND	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY				25a. REC'D BY REGISTRAR NOV 24 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

13382

13382

ST. MARY'S

MARYLAND

ST. MARY'S

ST. GEORGE ISLAND

4 DAY

LEONARDTOWN

ST. MARY'S HOSPITAL

NOVEMBER

BROWN

FRANKLIN

BARVIA

AUGUST 1, 1902

WHITE

U.S.A.

WATZMAN

WHITE CHERRY

GENERAL BRIDGE ST. GEORGE ISLAND, MARYLAND

NOV. 17, 1902

ST. GEORGE ISLAND, ST. MARY'S

ST. GEORGE ISLAND

NOV. 17, 1902

SURVIVAL

ST. GEORGE ISLAND, MARYLAND

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BUSHWOOD		c. LENGTH OF STAY IN TB LIFE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL BUSHWOOD	
3. NAME OF DECEASED (Type or print) First Middle Last ROBERT GARRETT CHESELDINE		4. DATE OF DEATH Month Day Year NOVEMBER 28, 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 3, 1913
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER		10b. KIND OF BUSINESS OR INDUSTRY FREIGHT	
11. BIRTHPLACE (County & State, or foreign country) BUSHWOOD, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GARRETT CHESELDINE		14. MOTHER'S MAIDEN NAME MARY L. GASS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WW II		16. SOCIAL SECURITY NO.	
17. INFORMANT MARY P. CHESELDINE		Address BUSHWOOD, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypoxia DUE TO metastatic obstruction airway CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Squamous cell Carcinoma tongue DUE TO (c) 1 1/2 yrs		INTERVAL BETWEEN ONSET AND DEATH 3 wk.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE John F. Fenwick M. D.		22b. DATE SIGNED 11.30.67	
22c. PHYSICIAN'S NAME (Type) JOHN F. FENWICK M. D.		22d. ADDRESS LEONARDTOWN, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-1-67	
23c. NAME OF CEMETERY OR CREMATORY SACRED HEART		23d. LOCATION (City or Town) (County) (State) BUSHWOOD, ST. MARY'S, MD.	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		25a. REC'D BY REGISTRAR DEC 1 1967	
ADDRESS LEONARDTOWN, MARYLAND		25b. REGISTRAR'S SIGNATURE Charles Judge	

1895

STATE DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
STATE OF MARYLAND
BUREAU OF VITAL STATISTICS
STATE OF MARYLAND

ST. MARY'S

MARYLAND

DEATH

ST. MARY'S

BUSHWOOD

RURAL

LIFE

BUSHWOOD

NOVEMBER 1895

CHESTER

CHESTER

ROBERT

24

1895

X

WHITE

MALE

U.S.A.

BUSHWOOD, MARYLAND

RIGHT

RIGHT

MARY L. LAR

BARNETT CHESTER

MARY F. CHESTER BUSHWOOD, MARYLAND

[Faint, illegible handwritten text, possibly a signature or address]

LEONARDTOWN, MARYLAND

JOHN F. FENWICK M. D.

BUSHWOOD, ST. MARY'S

SACRED HEART

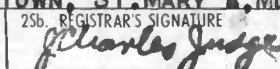
LEONARDTOWN, MARYLAND

W. CARRE MATTHEW LEONARDTOWN, MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY St. Mary's					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN				c. LENGTH OF STAY IN 1b 6 MONTHS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Mary's Nursing Home						d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM MARRICE CLEMENTS						4. DATE OF DEATH Month Day Year NOVEMBER 28, 19 67					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 24, 1886		9. AGE (In years lost birthday) yrs. 80		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Service				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN CLEMENTS						14. MOTHER'S MAIDEN NAME ROSA JARBOE					
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) (If yes give war or dates of service) W W Yes				16. SOCIAL SECURITY NO. 578-48-8399		17. INFORMANT Address DELLA R. CLEMENTS LEONARDTOWN, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Generalized Arteriosclerosis										INTERVAL BETWEEN ONSET AND DEATH 2 days 10y1 10y1	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.											
22a. SIGNATURE 						22b. DATE SIGNED 11.30.67		22c. PHYSICIAN'S NAME (Type) JOHN F. FENWICK M. D.			
22d. ADDRESS LEONARDTOWN, MARYLAND											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Dec. 1, 1967		23c. NAME OF CEMETERY OR CREMATORY St. Andrews		23d. LOCATION (City or Town) (County) (State) LEONARDTOWN, St. Mary's, Md.					
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND						25a. REC'D BY REGISTRAR DEC 1 1967		25b. REGISTRAR'S SIGNATURE 			

W. CLARK BATTLEY LEONARDTOWN, MARYLAND

BURIAL DEC. 1, 1907 ST. ANDREW

JOHN F. FENNICK M. D. LEONARDTOWN, MARYLAND

LEONARDTOWN, ST. MARY'S, D.

DEC 1 1907

57-12-700 CELIA R. CLEMENTS LEONARDTOWN, MD.

JOHN CLEMENTS

NEPA LARSON

CIVIL SERVICE

MARYLAND

ALL WHITE

DEC. 24, 1880

WILLIAM MARRIGE

CLEMENTS

NOVEMBER

ST. MARY'S MARSHING HOME

LEONARDTOWN

6 MONTHS

LEONARDTOWN

MARYLAND

ST. MARY'S

ST. MARY'S

LEONARDTOWN, MARYLAND

1880

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15965

CERTIFICATE OF DEATH

15957

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN,		c. LENGTH OF STAY IN 1b 12 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEXINGTON PARK,		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL			d. STREET ADDRESS LORD CALVERT TRAILER PARK		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First HAZEL Middle VIRGINIA Last COLLINS			4. DATE OF DEATH Month NOVEMBER Day 2, Year 19 67		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 29, 1905	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (County & State, or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME PRESTON SWEIGERT			14. MOTHER'S MAIDEN NAME HARREET CHUNEY		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 218-26-6780	17. INFORMANT WILLIAM COLLINS Address SAME AS # 2 ABOVE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) Atherosclerosis, genl. DUE TO (c) 5-6 yrs					INTERVAL BETWEEN ONSET AND DEATH 2 wks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 10/20, 1967 to Nov 2, 1967 , that (I) (we) lost saw the deceased alive on 11/1, 1967 , and that death occurred at M , from causes and on the date stated above.					
22a. SIGNATURE J. Roy Guyther		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED NOV. 2, 1967	
22c. PHYSICIAN'S NAME (Type) J. ROY GUYTHER M. D.		22d. ADDRESS MECHANISVILLE, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 11/5/67	23c. NAME OF CEMETERY OR CREMATORY LUTHERAN CHURCH CEM	23d. LOCATION (City or Town) (County) (State) BAKERSVILLE, WASH. CO. MD.		
24. FUNERAL DIRECTOR ROUZER FUNERAL HOME HAGERSTOWN, MARYLAND			25. FILED BY REGISTRAR NOV 6 1967		
			25b. REGISTRAR'S SIGNATURE Charles Judge		

U. S. GOVT. H. O.

THOMASVILLE, MARYLAND

Handwritten notes and signatures, including "J. H. Hager" and "J. H. Hager" in cursive.

NAME

218-30-0750

WILLIAM COLLINS

NAME AS IN S. ABOVE

PRESTON SWEIGERT

HARREY CHURCH

ROUSSEAU

218-30-0750

VIRGINIA U.S.A.

WHITE

JAN. 22, 1907

HAZEL

VIRGINIA

COLLINS

GOVERNOR S.

ST. MARY'S HOSPITAL

LEON CARROLL TRAILER PARK

EDWARD TOWN

12 DAYS

LEXINGTON PARK

ST. MARY'S

ANYLAND

ST. MARY'S

1907

1907

1907

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
15966									
15958									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN			c. LENGTH OF STAY IN 1b 5 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MECHANICSVILLE				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL					d. STREET ADDRESS R F D Box 355			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JEANETTE ELIZABETH CURTIS					4. DATE OF DEATH Month Day Year NOVEMBER 7, 1967				
5. SEX FEMALE		6. COLOR OR RACE COLORED		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 28, 1906		9. AGE (In years last birthday) yrs. 61	
10a. USUAL OCCUPATION (Give kind of work done during usual of working life, even if retired) HOUSE WIFE			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS GRAY					14. MOTHER'S MAIDEN NAME JANIE WOODLAND				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Address JAMES G. CURTIS SAME AS # 2 ABOVE				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO (b) <u>331x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <u>Nov 6</u> , 19 <u>67</u> , to <u>Nov 7</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Nov 6</u> , 19 <u>67</u> , and that death occurred at <u>M</u> , from causes on and on the date stated above. 22a. SIGNATURE <u>J Roy Guyther</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>J Roy Guyther M.D.</u> 22b. DATE SIGNED 22d. ADDRESS MECHANICSVILLE, MARYLAND									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Nov. 10, 1967		23c. NAME OF CEMETERY OR CREMATORY ST. JOSEPHS CEMETERY		23d. LOCATION (City or Town) (County) (State) MORGANZA, ST. MARY'S, MARYLAND			
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND					25a. REC'D BY REGISTRAR DATE NOV 14 1967		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

CLARK HATTLEY, LEONARDTOWN, MARYLAND

Nov. 10, 1943

St. Joseph Cemetery

Wichita, St. Mary, Maryland

MECHANICVILLE, MARYLAND

THOMAS GRAY

JAMIE WOODLAND

HOUSE WIFE

MARYLAND

FEMALE COLORED

FEB. 28, 1908

JENNIE ELIZABETH

CURTIS

B. VARY'S HOSPITAL

P. O. BOX 352

LEONARDTOWN

2 DAYS

MECHANICVILLE

ST. MARY'S

MARYLAND

ST. MARY'S

TESTATE OF GRAY

13258

1
2
3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15967

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15959

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ST. MARY'S			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PATUXENT RIVER		c. LENGTH OF STAY IN 1b 2 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEXINGTON PARK	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) STATION HOSPITAL			d. STREET ADDRESS RIDGE MD.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last KURT ALLAN DALKIN			4. DATE OF DEATH Month Day Year NOV 25 19 67		
5. SEX MALE	6. COLOR OR RACE CAUC	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 11-23-67		9. AGE (In years lost birthday) yrs. 0 2
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) ST. MARY'S, MD.	
13. FATHER'S NAME DARRELL HOWARD DALKIN			12. CITIZEN OF WHAT COUNTRY? USA		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address FATHER RIDGE MD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYALINE MEMBRAN DISEASE 7735 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PREMATURITY DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 2 DAYS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 23 NOV 19 67 , to 25 NOV 19 67 , that (I) (we) last saw the deceased alive on 25 NOV 19 67 , and that death occurred at 7:55 PM from causes and on the date stated above.					
22a. SIGNATURE James R. ABEL			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 25 NOV 67
22c. PHYSICIAN'S NAME (Type) James R. ABEL			22d. ADDRESS Same as #1		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 11/28/67	23c. NAME OF CEMETERY OR CREMATORY EBENEZER CEM.		23d. LOCATION (City or Town) (County) (State) GREAT MILLS, MD.	
24. FUNERAL DIRECTOR JOHN M. WELCH - LEONARDTOWN, MD.			25a. REC'D BY REGISTRAR DEC 1 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

12828

12828

STATE OF MARYLAND

ST. MARY'S

MARYLAND

EXHIBITION PARK

DATE

ST. MARY'S

ST. MARY'S

ST. MARY'S

NOV 22 1961

NOV 22 1961

NOV 22 1961

NOV 22 1961

11-22-61

11-22-61

NOV 22 1961

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NOV 22 1961

NOV 22 1961

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15968

15960

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL BUSHWOOD		c. LENGTH OF STAY IN 1b WEEK 7 YEARS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Ithamar E EGGLETON		4. DATE OF DEATH Month NOVEMBER Day 12 Year 1967	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 7, 1897
9. AGE (In years last birthday) 70 yrs.		10. BIRTHPLACE (State or foreign country) NORTH CAROLINA	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11b. KIND OF BUSINESS OR INDUSTRY	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. EATHER'S NAME JESSIE B. EGGLETON	
14. MOTHER'S MAIDEN NAME ? FONTAINE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. 231-16-8432		17. INFORMANT EDWARD EGGLETON	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 163x IMMEDIATE CAUSE (a) Co of Lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William D. Boyd M. D.		22. DATE SIGNED 11/13/67	
EXAMINER'S NAME (Type)		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-16-67	
23c. NAME OF CEMETERY OR CREMATORY Harmony Park		23d. LOCATION (City or Town) (County) (State) Landover Md	
24. FUNERAL DIRECTOR ARTHUR L. ROLLINS		25a. REC'D BY REGISTRAR WASHINGTON, D.C.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE NOV 15 1967	

18270

MASSACHUSETTS DEPARTMENT OF REVENUE
TAXPAYER'S STATEMENT OF DEBIT

18270

FOR STATE
REVENUE

ST. MARY'S

MARYLAND

ST. MARY'S

RURAL 800 WOOD
RURAL 800 WOOD
RURAL 800 WOOD

RURAL 800 WOOD

NOVEMBER 13, 1937

EDGELTON

E

THAMAM

TO

AUG 1, 1937

NO 80

AGE

U.S.A.

NORTH CAROLINA

FOUNTAIN

JEFFREY L. EGGLETON

231-10-2432 EDWARD EGGLETON 2003 - 286 LAKE BUILDING, NO.

Handwritten signature

Handwritten signature

WILLIAM D. GOOD M. D.

11/13/37

6-16-37 SOCIAL

WASHINGTON, D.C.

ARTHUR L. POLCING 1937 HUNT PLACE N.E.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. LENGTH OF STAY IN 1b 20 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S NURSING HOME		d. STREET ADDRESS MORGANZA	
3. NAME OF DECEASED (Type or print) First Middle Last ROSE LUCINA FORBES		4. DATE OF DEATH Month Day Year NOVEMBER 27, 1967	
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 6, 1900
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL HEBB		14. MOTHER'S MAIDEN NAME MARY PRICE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 217* 32-3934		16. SOCIAL SECURITY NO. 217* 32-3934	
17. INFORMANT LOUIS E. FORBES		Address MORGANZA, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral haemorrhage DUE TO (b) Cerebral arteriosclerosis DUE TO (c) Cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 26, 1967 to Nov 27, 1967 , that (I) (we) lost saw the deceased alive on Nov 26, 1967 , and that death occurred at 5 AM , from causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 11-29-67	
22c. PHYSICIAN'S NAME (Type) DAVIS MOSSMAN M. D.		22d. ADDRESS MECHANICSVILLE, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/30/1967	
23c. NAME OF CEMETERY OR CREMATORY ST. JOSEPH		23d. LOCATION (City or Town) (County) (State) MORGANZA ST. MARY, Md.	
24. FUNERAL DIRECTOR W. C. CLARKE MATTINGLEY, LEONARDTOWN Md.		25a. REC'D BY REGISTRAR DEC 5 1967	
25b. REGISTRAR'S SIGNATURE [Signature]			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15970

Item #236 Film #G395 11/28/67 ph

15962

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|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY ST. MARY'S MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ST. MARY'S | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
LEONARDTOWN | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
RURAL MECHANICSVILLE | |
| c. LENGTH OF STAY IN TB
19 DAYS | | d. STREET ADDRESS
18-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
ST. MARY'S HOSPITAL | | e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First GEORGE Middle K. Last GREEN | | 4. DATE OF DEATH
Month NOVEMBER Day 21 Year 19 67 | |
| 5. SEX
MALE | 6. COLOR OR RACE
NEGRO | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
SEPT. 14, 1882 |
| 9. AGE (In years last birthday)
85 yrs. | | 10. IF UNDER 1 YEAR, IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
FARMING | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
HENRY GREEN | | 14. MOTHER'S MAIDEN NAME
ROBETTA WILLIAMS | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or (unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
ROBERT V. YOUNG BRYANTOWN, MARYLAND | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
332x IMMEDIATE CAUSE (a) Cerebral thrombosis
DUE TO (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Cerebral arteriosclerosis
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Oct , 19 67 , to Nov , 19 67 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 11 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
[Signature] | | 22b. DATE SIGNED
11-22-67 | |
| 22c. PHYSICIAN'S NAME (Type)
[Signature] | | 22d. ADDRESS
MECHANICSVILLE, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE THEREOF
Nov. 25, 1967 | 23c. NAME OF CEMETERY OR CREMATORY
MT. CALVARY | 23d. LOCATION (City or Town) (County) (State)
NEW MARKET, ST. MARY'S, MARYLAND |
| 24. FUNERAL DIRECTOR
W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND | | 25a. REC'D BY REGISTRAR
NOV 24 1967 | |
| 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

H. CLARK MATTHEW, LEONARDTOWN, MARYLAND

ST. MARY'S

HOSPITAL

NEW MARKET, ST. MARY'S, MARYLAND

LEONARDTOWN, MARYLAND

HENRY COHEN

ROBERTA WILLIAMS

FARMING

MARYLAND

WALTER HEND

SEPT. 1, 1932

XX

GEORGE

GREEN

HYUNDOO

ST.

ST. MARY'S HOSPITAL

19 DAYS

RURAL

LEONARDTOWN

ST. MARY'S

MARYLAND

ST. MARY'S

12852

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

15971

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15963

CERTIFICATE OF DEATH

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|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY
ST. MARY'S
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
MARYLAND
b. COUNTY
ST. MARY'S | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
LEONARDTOWN | | c. LENGTH OF STAY IN 1b
1 DAY | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
ST. MARY'S HOSPITAL | | d. STREET ADDRESS
MORGANZA | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
JAMES THOMAS GUY | | 4. DATE OF DEATH
Month Day Year
NOVEMBER 11, 1967 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
SEPT. 14, 1911 |
| 9. AGE (In years lost birthday)
56 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
FARMING | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
JOHN EDWARD GUY | | 14. MOTHER'S MAIDEN NAME
MARY KXXXXX BLANCHE GRAVES | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
213-12-2058 | |
| 17. INFORMANT
MARY T. GUY | | Address
SAME AS # 2 ABOVE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
450.0
IMMEDIATE CAUSE (a) Cardiac decompensation
DUE TO (b) Generalized ASCVD
DUE TO (c) Generalized ASCVD
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH
2 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m.
19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1957 to 11/11/67 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 11 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Leon W. Berube | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
LEON BERUBE M. D. | | 22d. ADDRESS
MECHANICSVILLE, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
Nov. 14, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY
ST. JOSEPHS CEMETERY | | 23d. LOCATION (City or Town) (County) (State)
MORGANZA, ST. MARY'S, MD. | |
| 24. FUNERAL DIRECTOR
W. CLARKE MATTINGLEY | | 25a. REC'D BY REGISTRAR
NOV 17 1967 | |
| 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | | |

J. CLARK HATTINLEY, LEONARDTOWN, MARYLAND

BURIAL May, 14, 1907, Mt. Lebanon Cemetery, Leonardtown, St. Mary's, Md.

Leon George H. O. Mechanicsville, Maryland

Six-12-1902 Mary T. Boy, same as S. above

John Edward Boy Mary Martin Clarke Chaves

Farming

Wife

X

James

Thomas

Day

Sept. 10, 1911

50

November 11, 07

St. Mary's Hospital

Leonardtown

Day

Worship

Harland

St. Mary's

St. Mary's

LEONARDTOWN OF MARY

1888

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 1-103. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

15972

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15964

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY ST. MARYS MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY ST. MARYS | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
St. Mary City | | c. LENGTH OF STAY IN 1b
18-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED
(Type or print)
STEVEN | | 4. DATE OF DEATH
Month November Day 15 Year 19 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
AUG. 8, 1912 |
| 9. AGE (In years last birthday)
55 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
CARPENTER | | 11b. KIND OF BUSINESS OR INDUSTRY
PUBLIC WORKS | |
| 12. BIRTHPLACE (State or foreign country)
PENNSYLVANIA | | 13. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 14. FATHER'S NAME
JOSEPH HOLISKEY | | 15. MOTHER'S MAIDEN NAME
MARY KUMPAN | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
NO | | 17. SOCIAL SECURITY NO.
217-14-7726 | |
| 18. INFORMANT
JOSEPHINE M. HOLISKEY | | 19. ADDRESS
RT. 1, Box 61 GLENCOE NEW SMYRNA BCH., FLA. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
490X IMMEDIATE CAUSE (a) Lobar pneumonia
DUE TO (b) _____
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Charles S. Springate, M.D. | | 22. DATE SIGNED
November 16, 1967 | |
| EXAMINER'S NAME (Type)
Charles S. Springate | | 23. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE THEREOF
11-18-67 | 23c. NAME OF CEMETERY OR CREMATORY
ST. JAMES CEMETERY | 23d. LOCATION (City or Town) (County) (State)
LEXINGTON PARK ST. MARY'S MD. |
| 24. FUNERAL DIRECTOR
JOHN M. WELCH | | 25a. REC'D BY REGISTRAR
NOV 22 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | 26. ADDRESS
LEONARDTOWN, MD. | |

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15965

15973

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY ST. MARY'S MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ST. MARY'S | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
LEONARDTOWN | | c. LENGTH OF STAY IN 1b
10 MONTHS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
ST. MARY'S NURSING HOME | | d. STREET ADDRESS
RURAL MECHANICSVILLE, | |
| e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 187 | |
| 3. NAME OF DECEASED (Type or print)
First ROBERT Middle BENEDICT Last HUNTINGTON | | 4. DATE OF DEATH
Month NOVEMBER Day 14 Year 1967 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
SEPT. 20, 1884 |
| 9. AGE (In years last birthday)
83 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
CIVIL SERVICE | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
LOUIS HUNTINGTON | | 14. MOTHER'S MAIDEN NAME
CATHERINE HILL | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
MRS JEANETTE HUNTINGTON | | Address
SAME AS # 2 ABOVE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4500
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
(c) | | INTERVAL BETWEEN ONSET AND DEATH
3 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Nov , 19 67 , to Nov , 19 67 , that (I) (we) last saw the deceased alive on Nov , 19 67 , and that death occurred at 11 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
David Mossman | | 22b. DATE SIGNED
11-15-67 | |
| 22c. PHYSICIAN'S NAME (Type)
DAVID MOSSMAN M. D. | | 22d. ADDRESS
MECHANICSVILLE MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
Nov. 17, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY
SACRED HEART CEMETERY | | 23d. LOCATION (City or Town) (County) (State)
BUSHWOOD, ST. MARY'S, MD. | |
| 24. FUNERAL DIRECTOR
W. CLARKE MATTINGLEY | | 25a. REC'D BY REGISTRAR
NOV 17 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1883

ST. MARY'S

MARYLAND

ST. MARY'S

MARYLAND

10 MONTHS

EDWARD W.

ST. MARY'S

MARYLAND

HUNTINGTON

BENEDICT

HUNTINGTON

1883

WHITE

MARYLAND

CIVIL SERVICE

CATHERINE HILL

LOUIS HUNTINGTON

ONE JEANETTE HUNTINGTON SAME AS 5 ABOVE

MARYLAND

DAVID HESMAN

BURDEN, ST. MARY'S

SACRED EAST CEMETERY

1883

BURIAL

W. CLARK HATHORN, LEONARDTOWN, MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|---|--|---|---|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY ST. MARY'S MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ST. MARY'S | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
RURAL HOLLYWOOD | | | c. LENGTH OF STAY IN 1b
14 YEARS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
HOLLYWOOD | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
ROUTE 1 Box 214 | | | | | d. STREET ADDRESS
ROUTE 1 Box 214 | | | e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First WILLARD Middle FOSTER Last JONES | | | | | 4. DATE OF DEATH
Month NOVEMBER Day 5 Year 1967 | | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
APRIL 28, 1888 | | 9. AGE (In years lost birthday) yrs. 79 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MINISTER | | 10b. KIND OF BUSINESS OR INDUSTRY
CLERGYMAN | | 11. BIRTHPLACE (County & State, or foreign country) | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
WILLIAM ROBERT JONES | | | | | 14. MOTHER'S MAIDEN NAME
MARTHA JANE PRINCE | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
226-14-8566 | | 17. INFORMANT
Address
MRS OLIVIA M. JONES SAME AS # 2 ABOVE | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis
DUE TO 260X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Proximal Myelitis
DUE TO Dilatative Vascular Disease
(c)
INTERVAL BETWEEN ONSET AND DEATH
1 hour
10 years
10 years | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from July 1 , 19 65 , to Nov 5 , 19 67 , that (I) (we) last saw the deceased alive on Nov 5 , 19 67 , and that death occurred at 2A M, from causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
W.H. Patrick | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22b. DATE SIGNED
11-6-67 | |
| 22c. PHYSICIAN'S NAME (Type)
WILLIAM H. PATRICK M. D. | | | | | 22d. ADDRESS
LEXINGTON PARK, MARYLAND | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
Nov. 8, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY
TRINITY MEMORIAL | | | 23d. LOCATION (City or Town) (County) (State)
WALDORF, CHARLES, MARYLAND | | |
| 24. FUNERAL DIRECTOR
W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND | | | | | 25a. REC'D BY REGISTRAR
DATE NOV 8 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

10000

TESTIMONY OF WITNESS

ST. MARY'S

MARYLAND

ST. MARY'S

CLYDE

14 YEARS

WILLIAM

RURAL

X

ROUTE 1 BOX 214

ROUTE 1 BOX 214

67

NOVEMBER 2, 1950

JONES

FOUR

FIELD

APRIL 2, 1950

WHITE

MALE

U.S.A.

CLERKMAN

MINISTER

MARTIN GARY JONES

WILLIAM ROBERT JONES

22-14-3500 AS OLIVIA JONES BORN AT 2 ABOVE

LEXINGTON PARK, MARYLAND

WILLIAM H. PATRICK M.D.

WILSON, CHARLES, MARYLAND

THIRTY CHORAL

NOV. 6, 1950

SERIAL

W. CLARK KATTELEY, LEONARDTOWN, MARYLAND

1
FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15975

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15967

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY ST. MARY'S MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ST. MARY'S | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
LEXINGTON | | c. LENGTH OF STAY IN lb
24 HRS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
167 CHINLEE DRIVE | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
THOMAS WILLIAM KUBE | | 4. DATE OF DEATH
Month Day Year
NOVEMBER 10, 19 67 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
JULY 5, 1917 |
| 9. AGE (In years last birthday) yrs.
50 | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
LABOR | | 11b. KIND OF BUSINESS OR INDUSTRY | |
| 12. BIRTHPLACE (State or foreign country)
VIRGINIA | | 13. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 14. FATHER'S NAME
BERNARD KUBE | | 15. MOTHER'S MAIDEN NAME
? ? | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 17. SOCIAL SECURITY NO. | |
| 18. INFORMANT
MRS JAMES L. MORGAN | | Address
SAME AS # 2 ABOVE | |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) asphyxiation - immediate
3220 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) aspiration - immediate
DUE TO (c) acute alcoholism | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
<i>William D. Boyd</i>
EXAMINER'S NAME (Type) William D. Boyd, MD, Asst. Med. Examiner | | 22. DATE SIGNED
11/11/67 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
Nov. 14, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY
THORN ROSE CEMETERY | | 23d. LOCATION (City or Town) (County) (State)
STAUNTON, VA. | |
| 24. FUNERAL DIRECTOR
HAMRICK FUNERAL HOME | | 25a. REC'D BY REGISTRAR
NOV 17 1967 | |
| 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | |

1957

1957

ST. LOUIS

ST. LOUIS

ST. LOUIS

ST. LOUIS

ST. LOUIS

ST. LOUIS

ST. LOUIS

ST. LOUIS

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10 JULY 2, 1957

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U.S.A.

U.S.A.

LABOR

GERHARD KUBZ

MRS JAMES L. HOBAN, SAME AS ABOVE

ST. LOUIS - 1957

ST. LOUIS - 1957

ST. LOUIS - 1957

ST. LOUIS - 1957

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HAMILTON FEDERAL HOME, ST. LOUIS, VIRGINIA

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #1d Film #G395 11/28/67 ph

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15976

15968

| | | | | | | | |
|--|----------------------------------|--|--|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY ST. MARY'S MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ST. MARY'S | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
LEONARDTOWN | | | | c. LENGTH OF STAY IN 1b
18-1 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Pete's Willows Bar- Rt. 5 | | | | d. STREET ADDRESS
RURAL LEONARDTOWN | | | |
| 3. NAME OF DECEASED
(Type or print) PETER CHRISTOPHER (CHRISTOS) LEVANIS | | | | 4. DATE OF DEATH
Month NOVEMBER Day 17 Year 19 67 | | | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH
MARCH 5, 1918 | | 9. AGE (In years last birthday)
49 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
BAR PROPRIETOR | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
GREGORY LEVANIS | | | | 14. MOTHER'S MAIDEN NAME
? ? | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) YES | | 16. SOCIAL SECURITY NO.
218-03-9468 | | 17. INFORMANT
MICHAEL LEVANIS Address BALTIMORE, MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
493X IMMEDIATE CAUSE (a) Pneumonia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO
(c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
William D. Boyd M.D. | | | | 22. DATE SIGNED
11-18-67 | | | |
| EXAMINER'S NAME (Type)
WILLIAM D. BOYD M. D. | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
Address (Street, city, town, or county) | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
Nov. 20, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY
GREEK ORTHODOX | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE 7, MARYLAND | |
| 24. FUNERAL DIRECTOR
MATTHEWS FUNERAL HOME 3021 EASTERN AVE. | | | | 25a. REC'D BY REGISTRAR
DATE NOV 21 1967 | | 25b. REGISTRAR'S SIGNATURE
<i>John A. Judge</i> | |

1000

1000

ST. MARY'S

MARYLAND

ST. MARY'S

LEONARDTOWN

RURAL LEONARDTOWN

PETER CHRISTOPHER (CHRISTOPHER) LEVANS

NOVEMBER

07

MALE WHITE

MARCH 2, 1918

NO

LABORER

MARYLAND

U.S.A.

REBORN LEVANS

BALTIMORE, MD.

ES

21-100-0000 MICHAEL LEVANS 619 WEST 30TH STREET

BURIAL

NOV. 20, 1907

GREEN ORTHODOX

BALTIMORE, MD.

MARYLAND

CATHERINE BURIAL HOME 3031 EASTERN AVE.

BALTIMORE, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| <div style="display: flex; justify-content: space-between;"> <div> <p>15977</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</p> </div> <div> <p>15969</p> </div> </div> <p style="text-align: center;">CERTIFICATE OF DEATH</p> | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY St. Mary's MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
NAS, Patuxent River
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Station Hospital | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Lexington Park
d. STREET ADDRESS
530 Saratoga Drive
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED
(Type or print) June Stokes Longfellow
First Middle Last
Female Caucasian WIDOWED NEVER MARRIED
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife
10b. KIND OF BUSINESS OR INDUSTRY
USMC/Dependent
11. BIRTHPLACE (County & State, or foreign country)
Ohio
12. CITIZEN OF WHAT COUNTRY?
U.S. | | | | | | 4. DATE OF DEATH November 14, 1967
Month Day Year
9. AGE (In years lost birthday) 47 yrs.
IF UNDER 1 YEAR Months Days Hours Min.
13. FATHER'S NAME
1st Name Unknown (STOKES) deceased
14. MOTHER'S MAIDEN NAME
Gertrude Wilderson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
NO
16. SOCIAL SECURITY NO.
280-18-7547
17. INFORMANT George M. Longfellow (H) same address. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Infarction
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Arteriosclerotic Cardiovascular Disease.
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Myocardial Infarction
20c. TIME OF INJURY Month, Day, Year 11:16 p.m. Nov. 14, 1967
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
20f. (City or town) (County) (State) Lexington Park, St. Mary's Md.
21. I certify that (I) (this hospital) attended the deceased from Nov. 14, 1967, to Nov. 14, 1967, that (I) (we) last saw the deceased alive on Nov. 14, 1967, and that death occurred at 3:40 PM from causes on and on the date stated above.
22a. SIGNATURE <i>[Signature]</i>
22b. DATE SIGNED 14 NOV 67
22c. PHYSICIAN'S NAME (Type) J. S. LEIGHTON, LCDR, MC, USN
22d. ADDRESS NAS, Patuxent River, Md. 20670
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE THEREOF NOV. 20, 1967
23c. NAME OF CEMETERY OR CREMATORY ARLINGTON CEMETERY
23d. LOCATION (City or Town) (County) (State) ARLINGTON, VA.
24. FUNERAL DIRECTOR JOHN M. WELCH
25a. REC'D BY REGISTRAR NOV 22 1967
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | | | | | | | |

STATE OF OHIO

Wm. W. W.

Wm. W. W.

Wm. W. W.

Wm. W. W.

Wm. W. W.

Wm. W. W.

Wm. W. W.

Wm. W. W.

Wm. W. W.

Wm. W. W.

Wm. W. W.

Wm. W. W.

Wm. W. W.

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Wm. W. W.

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Wm. W. W.

2

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15978

CERTIFICATE OF DEATH

15970

| | | | | | | | |
|---|--|--|---|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY ST. MARY'S MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
o. STATE MARYLAND b. COUNTY ST. MARY'S | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
LEONARDTOWN | | | c. LENGTH OF STAY IN 1b
7 WEEKS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CALIFORNIA | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
ST. MARY'S HOSPITAL | | | | d. STREET ADDRESS
STAR ROUTE Box 123 | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First MARY Middle WINIFRED Last MOORCONES | | | | 4. DATE OF DEATH
Month NOVEMBER Day 26 Year 19 67 | | | |
| 5. SEX
FEMALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
JUNE 12, 1905 | |
| 9. AGE (In years last birthday)
62 yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
SCHOOL TEACHER | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
PENNA. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 13. FATHER'S NAME
JOSEPH W. SHORT | | | |
| 14. MOTHER'S MAIDEN NAME
WINIFRED McTERIN CLARKE | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or, unknown) 16. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT
JOSEPH J. MOORCONES | | | | Address
SAME AS # 2 ABOVE | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of the ovary.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
16 mos. | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour a.m. Month, Day, Year
p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Jan , 19 66 , to Nov-26, 1967 that (I) was last saw the deceased alive on Nov-26, 1967 , and that death occurred at 4:23 P.M. from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
W. H. Patrick | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
11-27-67 | |
| 22c. PHYSICIAN'S NAME (Type)
WILLIAM H. PATRICK M. D. | | | | 22d. ADDRESS
LEXINGTON PARK, MARYLAND | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
Nov. 29, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY
HOLY FACE CEMETERY | | 23d. LOCATION (City or Town) (County) (State)
GREAT MILLS, ST. MARY'S MD. | |
| 24. FUNERAL DIRECTOR
W. CLARKE MATTINGLEY | | | | ADDRESS
LEONARDTOWN, MARYLAND | | 25a. REC'D BY REGISTRAR
DEC 1 1967 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

CLARK MAT INLEY, LEONARDTOWN, MARYLAND

NOV. 29, 1907 HOLY FACE OF MARY

WATER HILLS, MARYLAND

WILLIAM H. PATRICK, M. D.

LEXINGTON PARK, MARYLAND

NOV. 29, 1907

HOLY FACE OF MARY

WATER HILLS, MARYLAND

CLARK MAT INLEY, LEONARDTOWN, MARYLAND

NOV. 29, 1907 HOLY FACE OF MARY

WATER HILLS, MARYLAND

WILLIAM H. PATRICK, M. D.

LEXINGTON PARK, MARYLAND

NOV. 29, 1907

HOLY FACE OF MARY

WATER HILLS, MARYLAND

4 1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15973

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15971

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY ST. MARY'S MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY St. Mary's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Lexington Park | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Patuxent River Naval Air Station | | d. STREET ADDRESS
425 Essex Drive | |
| 3. NAME OF DECEASED (Type or print)
First MARY ANN Middle WAYNEWRIGHT Last MOORE | | 4. DATE OF DEATH
Month November Day 25 Year 19 67 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | B. DATE OF BIRTH
5/14/1935 |
| 9. AGE (In years last birthday) yrs. 32 | | IF UNDER 1 YEAR
Months 18 Days 1 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY
DOMESTIC | |
| 11. BIRTHPLACE (State or foreign country)
FLORIDA | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
GERALD WAINWRIGHT | | 14. MOTHER'S MAIDEN NAME
MIRIAM UNKNOWN | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
BOBBY R. HOLT | | Address
SAME AS # 2 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Fatty metamorphosis of liver
581.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) DUE TO
(c) DUE TO | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Charles S. Springate M.D.
EXAMINER'S NAME (Type) Charles S. Springate, M.D. | | 22. DATE SIGNED
November 26, 1967 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
TRANSIT | | 23b. DATE THEREOF
11/27/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
JOHN M. WELCH - LEONARDTOWN, MD. | | 23d. LOCATION (City or Town) (County) (State)
JACKSONVILLE, FLORIDA | |
| 24. FUNERAL DIRECTOR
JOHN M. WELCH | | 25a. REC'D BY REGISTRAR
NOV 29 1967 | |
| 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | |

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|----------------------------------|--|--|--|--|--|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 15980 Item #11 infor, taken from birth cert. ph 15972 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY
St. Mary's
MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
St. Mary's | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Leonardtown | | | | | | c. LENGTH OF STAY IN 1b
Bushwood | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Saint Mary's Hospital | | | | | | d. STREET ADDRESS
181 | | | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
James Randolph Morgan II | | | | | | 4. DATE OF DEATH
Month Day Year
11 8 19 67 | | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
11-7-67 | | 9. AGE (In years last birthday)
yrs. Months Days Hours Min.
1 11 8 19 67 | | 10. IF UNDER 1 YEAR
IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Leonardtown, St. M. Co. | | | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
James Randolph Morgan, Sr. | | | | | | 14. MOTHER'S MAIDEN NAME
Clara May Joy | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16. SOCIAL SECURITY NO. (If yes give war or dates of service) | | 17. INFORMANT
Address
Mother Bushwood, Maryland | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 7625 Cerebral; by acute meningitis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity
(c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 11/7 , 19 67 , to 11/8 , 19 67 , that (I) (we) last saw the deceased alive on 11/8/67 19 67 , and that death occurred at 11/8 M, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
J. Roy Guyther | | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | | | |
| 22c. PHYSICIAN'S NAME (Type)
J. Roy Guyther, M.D. | | | | | | 22d. ADDRESS
Mechanicsville, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 23b. DATE THEREOF
11-10-67 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Joseph Cemetery | | 23d. LOCATION (City, town or county) (State)
Morganza Md. | | | |
| 24. FUNERAL DIRECTOR
Mattingley's | | | | 24b. ADDRESS
Leonardtown, Maryland | | 25a. REC'D BY REGISTRAR
NOV 14 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

7-252733

11-7-67

James Randolph, Jr.
11-7-67

James Randolph, Jr.
11-7-67

James Randolph, Jr.
11-7-67

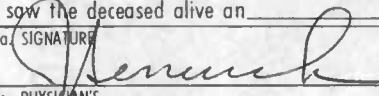
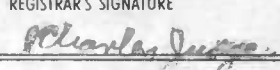
James Randolph, Jr.
11-7-67

James Randolph, Jr.
11-7-67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| <div>15981</div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> </div> <div>15973</div> | | | | | | | | | |
|--|--|--|---|---|---|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY St. Mary's MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN
c. LENGTH OF STAY IN 1b 10 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Mary's Hospital | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) AVENUE
d. STREET ADDRESS 18-1
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print)
First ANNIE Middle VIOLA Last St. Clair | | | | | 4. DATE OF DEATH Month NOVEMBER Day 25 Year 1967 | | | | |
| 5. SEX
FEMALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
FEB. 2, 1887 | | 9. AGE (In years last birthday) 80 yrs.
IF UNDER 1 YEAR: Months _____ Days _____
IF UNDER 24 HRS.: Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSE WIFE | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
MARYLAND | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
DOMINIC WISE | | | | | 14. MOTHER'S MAIDEN NAME
LILLIAN YATES | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address GENEVEIVE St. CLAIR STONE | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
4201 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive, Cerebrovascular Heart Disease
DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____ | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
5 days
10 years | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour _____ a.m. _____ p.m. 19 | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
 | | | | | 22b. DATE SIGNED
11.26.67 | | 22c. PHYSICIAN'S NAME (Type)
JOHN F. FENWICK M. D. | | |
| 22d. ADDRESS
LEONARDTOWN, MARYLAND | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
Nov. 27, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY
SACRED HEART CEMETERY | | | 23d. LOCATION (City or Town) (County) (State)
BUSHWOOD, St. Mary's, Md. | | |
| 24. FUNERAL DIRECTOR
W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND | | | | | 25a. REC'D BY REGISTRAR
NOV 28 1967 | | 25b. REGISTRAR'S SIGNATURE
 | | |

2082

2223

ST. MARY'S

MARYLAND

ST. MARY'S

AVENUE

TO DAVE

LEONARDTOWN

ST. MARY'S HOSPITAL

ST

GOVERNOR

ST. CLAIR

VICIA

ANNIE

80

FEB. 2, 1927

FEMALE WHITE

U.S.A.

MARYLAND

HOUSE WIFE

LILLIAN YATER

DOMINIC WISE

DEMENTIVE ST. CLAIR STONE

Handwritten notes:
M. Yater is wife of St. Clair Stone
Lillian Yater is daughter of St. Clair Stone

LEONARDTOWN, MARYLAND

JOHN F. FENWICK, ST. D.

BURWOOD, ST. MARY'S, MD.

SACRED HEART DEMENTARY

NOV. 27, 1927

BURIAL

CLARENCE MATTINGLY, LEONARDTOWN, MARYLAND

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15982

15974

| | | | | | | | |
|--|--|---|---|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY ST. MARY'S MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ST. MARY'S | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
LEONARDTOWN | | | c. LENGTH OF STAY IN 1b
2 HRS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
MCHANICSBVILLE | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
ST. MARY'S HOSPITAL | | | | d. STREET ADDRESS
ROUTE 1 Box 177 | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
GEORGE RALPH TAYLOR | | | | 4. DATE OF DEATH
Month Day Year
NOVEMBER 12, 19 67 | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. B. DATE OF BIRTH
Nov. 8, 1934 | |
| 9. AGE (In years last birthday) yrs.
33 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
SHEET METAL | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 13. FATHER'S NAME
ANDREW TAYLOR | | | |
| 14. MOTHER'S MAIDEN NAME
RUTH WILLET | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO.
579-44-8712 | | 17. INFORMANT
Address
DOROTHY D. TAYLOR SAME AS # 2 ABOVE | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Brain Laceration
DUE TO Basal Fracture
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
2 Hrs
1/2 Hr |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Driver of auto hit by another auto | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m.
1:15 - 10-12 1967 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)
ROUTE 5 | | 20f. (City or town) (County) (State)
Mechanicsville St Marys Md | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
William D. Boyd
EXAMINER'S NAME (Type)
WILLIAM D. BOYD M. D. | | | | 22. DATE SIGNED
11/13/67 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
Nov. 14, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY
EBENEZER - GREAT MILLS | | 23d. LOCATION (City or Town) (County) (State)
St. Mary's, Md. | |
| 24. FUNERAL DIRECTOR
W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND | | | | 25a. REC'D BY REGISTRAR
NOV 17 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Jones | |

MEDICAL CERTIFICATION

23934

23934

ST. LARRY'S

MARYLAND

ST. LARRY'S

MARYLAND

ST. LARRY'S

MARYLAND

ROUTE 1 BOX 111

ST. LARRY'S HOSPITAL

67

11

NOVEMBER

TAYLOR

MARYLAND

ST. LARRY'S

11

NOV. 8, 1934

X

WHITE

MALE

U.S.A.

MARYLAND

SHEET METAL

RUTH TAYLOR

ANDREW TAYLOR

ST. LARRY'S HOSPITAL, NORTH D. AVENUE, RAYNE, S. S. ABOVE

From the ...
... ..

X

X

112 - 11 11 - 1

X

WILLIAM D. BOYD, M.D.

BETWEEN GREAT VILLES
ST. LARRY'S HOSPITAL

WILLIAM D. BOYD, M.D.

NOV. 14, 1937

BURIAL

ST. LARRY'S HOSPITAL, MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15983

CERTIFICATE OF DEATH

15975

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
o. COUNTY ST. MARY'S MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
o. STATE MARYLAND b. COUNTY ST. MARY'S | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
LEONARDTOWN | | c. LENGTH OF STAY IN 1b
1 DAY | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
ST. MARY'S HOSPITAL | | d. STREET ADDRESS
ORAVILLE, MECHANICSVILLE | |
| 3. NAME OF DECEASED (Type or print)
First ROBERTA Middle WHALEN Last | | 4. DATE OF DEATH
Month NOVEMBER Day 8 Year 1967 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
COLORED | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
OCT. 7, 1920 |
| 9. AGE (In years lost birthday)
47 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
JOSEPH BOND | | 14. MOTHER'S MAIDEN NAME
NANIE BRISCOE | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
JAMES A. WHALEN 406 RIGGS ROAD N.E. WASH. D.C. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line 1(a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Electrolyte Imbalance
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Diabetes Acidosis
(c) 18h | | | INTERVAL BETWEEN ONSET AND DEATH
12h |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Nov 4, 1967 to Nov 4, 1967 , that (I) (we) last saw the deceased alive on Nov 4, 1967 , and that death occurred at M , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
David Mossman | | 22b. DATE SIGNED
11/16/67 | |
| 22c. PHYSICIAN'S NAME (Type)
DAVID MOSSMAN M. D. | | 22d. ADDRESS
MECHANICSVILLE, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE THEREOF
Nov. 9, 1967 | 23c. NAME OF CEMETERY OR CREMATORY
ST. JOSEPHS CEMETERY | 23d. LOCATION (City or Town) (County) (State)
MORGANZA, ST. MARY'S, MARYLAND |
| 24. FUNERAL DIRECTOR
W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND | | 25a. REC'D BY REGISTRAR
NOV 14 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

15075

CONFIDENTIAL

ST. MARY'S

MARYLAND

ST. MARY'S

LEONARDTOWN

CRANFORD

1 DAY

LEONARDTOWN

ST. MARY'S HOSPITAL

ROBERTA

BRANCH

NOVEMBER 8, 1957

Oct. 7, 1957

FEARLE COLORED

MARYLAND

WANT TO KNOW

JOHN BOND

James A. (Helen and Rina) Road N. 11th St.

LEONARDTOWN, MARYLAND

DAVID HOSKINS

NOVEMBER 8, 1957, ST. MARY'S, MARYLAND

ST. MARY'S HOSPITAL

NOV. 7, 1957

DEATH

CLARK HATFIELD, LEONARDTOWN, MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15984

15976

| | | | | | | | |
|--|----------------------------------|---|--|---|--|---|--|
| 1. PLACE OF DEATH
o. COUNTY ST. MARY'S MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
o. STATE MARYLAND b. COUNTY ST. MARY'S | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
LEONARDTOWN, | | | | c. LENGTH OF STAY IN 1b
9 DAYS | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
ST. MARY'S HOSPITAL | | | | d. STREET ADDRESS
18-1 | | | |
| 3. NAME OF DECEASED (Type or print)
First JOSEPH Middle KEATING Last WOODBURN | | | | 4. DATE OF DEATH
Month NOVEMBER Day 21, Year 19 67 | | | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
DEC. 17, 1885 | | 9. AGE (In years birthday) yrs.
81 | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
FARMING | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
RICHARD K. WOODBURN | | | | 14. MOTHER'S MAIDEN NAME
SUSIE C. GRAVES | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
215-56-9800 | | 17. INFORMANT Address
J. CLAUDE JOHNSON MORGANZA, MARYLAND | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line or (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 1530
DUE TO Circulatory Collapse
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) G.I. Hemorrhage
DUE TO Leucocarcinoma of Cecum
(c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
1530
days
months? | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (1) (this hospital) attended the deceased from 11/20/67 , 19 66 , to 11/21/67 , 19 67 , that (1) (we) last saw the deceased alive on 11/20/67 , 19 67 , and that death occurred at M , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
James P. Jarboe | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
11/21/67 | | | |
| 22c. PHYSICIAN'S NAME (Type)
James P. Jarboe M.D. | | 22d. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
Nov. 23, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY
ST. JOSEPH'S | | 23d. LOCATION (City or Town) (County) (State)
MORGANZA, ST. MARY'S, MARYLAND | |
| 24. FUNERAL DIRECTOR
W. CLARKE MATTINGLEY | | | | 25a. REC'D BY REGISTRAR
NOV 24 1967 | | 25b. REGISTRAR'S SIGNATURE
John J. Jones | |

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME 51
6M 1/67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15985

15977

| | | | |
|--|-------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY ST. MARY'S MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ST. MARY'S | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
RURAL AVENUE | | c. LENGTH OF STAY IN 1b
LIFE | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First TERRY Middle ANDRE Last YOUNG | | 4. DATE OF DEATH NOVEMBER 22, 1967 | |
| 5. SEX MALE | 6. COLOR OR RACE NEGRO | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH MAY 25, 1962 |
| 9. AGE (In years last birthday) 5 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13. FATHER'S NAME JAMES E. YOUNG SR. | | 14. MOTHER'S MAIDEN NAME GERTRUDE ELIZABETH ARMSTRONG | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT JAMES E. YOUNG SR. | | Address AVENUE, MARYLAND | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BURNS EXTREME
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | INTERVAL BETWEEN ONSET AND DEATH IMMED |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) HOUSE FIRE | |
| 20c. TIME OF INJURY Month, Day, Year 10/31 11/22 1967 | | 20d. INJURY OCCURRED <input checked="" type="checkbox"/> While at work <input type="checkbox"/> Not While at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME | | 20f. (City or town) ABELL (County) ST. MARY'S (State) MD | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE William D. Boyd
EXAMINER'S NAME (Type) WILLIAM D. BOYD M. D. | | 22. DATE SIGNED 11/24/67 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF NOV. 25, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY SACRED HEART CEMETERY | | 23d. LOCATION (City or Town) (County) (State) BUSHWOOD, ST. MARY'S, MARYLAND | |
| 24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY | | 25a. REC'D BY REGISTRAR NOV 28 1967 | |
| ADDRESS LEONARDTOWN, MARYLAND | | 25b. REGISTRAR'S SIGNATURE William D. Boyd | |

W. CLARK WATKINSLEY LEONARDTOWN, MARYLAND

BURIAL

NOV. 22, 1907

SACRED HEART CEMETERY

GROUNDS, ST. MARY'S, MARYLAND

WILLIAM J. BOYD N. O.

11/24/07

HOUSE FIRE

X HOME

ABELL

11/24/07

WILLIAM J. BOYD N. O.

11/24/07

JAMES C. YOUNG JR.

LEONARDO ELIZABETH ARMSTRONG

JAMES C. YOUNG JR.

AVENUE, MARYLAND

WILLIAM J. BOYD N. O.

MAY 22, 1907

3

XX

YOUNG

GOVERNOR

22

HOUSE

RURAL AVENUE

LIFE

RURAL AVENUE

ST. MARY'S

ST. MARY'S

MARYLAND

ST. MARY'S